EAP MANDATORY REFERRALS
CONSENT FOR RELEASE OF INFORMATION

I, _____, having a date of birth of _____, and a social security number of _____, do hereby acknowledge that I have been referred by _____, my employer for an evaluation and/or treatment at Deer Oaks EAP Services, L.L.C. under the benefit of my Employee Assistance Program.

I acknowledge that part of the reason for this evaluation and/or treatment pertains to my employment with _____, in as much as there may be concerns about my job performance. I therefore understand that it will be important for my Employer to receive information/feedback regarding my Evaluation/Treatment at Deer Oaks EAP Services, L.L.C., and that Deer Oaks may need to receive information/feedback from my Employer regarding my employment.

Consequently, I do hereby consent to the exchange and/or disclosure of information between Deer Oaks EAP Services, L.L.C., and my Employer, _____, regarding my evaluation and treatment at Deer Oaks EAP Services, L.L.C.. I acknowledge that I have the legal right to grant this authorization for release of information. I give complete authorization to both Deer Oaks EAP Services, L.L.C. and to my Employer, _____, to determine the nature of the information to be disclosed and to release whatever information may be relevant for either party to know.

This release of information may include data regarding drug and alcohol testing, evaluation, treatment as well as all other psychological, psychiatric and mental health records. This release may also include data related to my employment (e.g. job performance, job attendance, interactions with co-workers/supervisors, behavior/attitude in the workplace, changes demonstrated over time, etc.). I understand that the disclosure of information and records herein is done so within the context of either facilitating continuity of care, diagnosis and treatment planning and/or in order to facilitate my Employer's and/or treating clinician's understanding of factors which may contribute to my performance and well-being in the workplace.

I understand that my record may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Prt. 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon termination of treatment unless otherwise specified.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____ _____
Signature of Witness Date